Cedar Valley Medical SPECIALISTS P.C.
We specialize in you.℠

Worker's Compensation
Standard Authorization to Disclose Protected Health Information/Medical Records Release Form

1._____ _____ _____
(Patient's Name) (Date of birth) (Social Security Number)

_____
(Street Address) (City) (State) (Zip Code)

_____
(Phone)

I authorize Cedar Valley Medical Specialists, P.C. to release to the party in section 3 the following information from my medical records. (Check the appropriate items)

Was This Injury Reported to Your Employer? YES_____ NO_____
Employers' Name:_____
Address: _____
Phone:_____
Date of Injury:_____ **Site of Injury:**_____

2. ☐ **Complete Medical Record** [This will include pertinent past medical history, previous surgery and/or injury, psychiatric (mental health) information, HIV and/or AIDS related diagnoses, evaluation information, and substance abuse (drug or alcohol) information]

☐ **Partial Medical Record- Do <u>not</u> include the following areas of my records in this release:**
- ☐ Psychiatric (mental health) information.
- ☐ HIV and / or Aids related diagnosis evaluation information.
- ☐ Substance Abuse (Drug or Alcohol) information.

[This will include pertinent past medical history, previous surgery and/or injury.]

3. My medical record may be copied and released to my employer where the injury took place, the employer's insurance carrier, any case manager assigned to my case by the employer, or employee's insurance carrier for the purpose of <u>Worker's Compensation Claims</u>.

4. _____ _____
(Patient, Parent or legal guardian's Signature) (Date)

_____ _____
(maiden/previous name if applicable) Authority (Description)

I understand that I have the right to inspect the disclosed information at any time.
This authorization is effective for one year from the date it is signed. I understand I may revoke this authorization at any time, by giving written notice to the healthcare provider or record keeper. Refer to Cedar Valley Medical Specialists, P.C.'s Notice of Privacy Practices for exceptions to the right to revoke.

Date Sent_____ Initials_____

Federal and/or state law specifically require that any disclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:
This information has been disclosed to you from records protected by Federal Confientiality rules (42CFR Part2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part2. A general authorization for the release medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or persecute any alcohol or drug abuse patient.
See also chapter 228 of the Iowa code and section 141.23(3) of the Iowa Code and other applicable laws.
The consequences to the individual of a refusal to sign the authorization when, in accordance with §164.508of the HIPAA law, the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.
The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this subpart.